



Boston Public Health Commission
HIV/AIDS Services Division
Infectious Disease Bureau
1010 Massachusetts Avenue
Boston, MA 02118
(617) 534-4559



Massachusetts Department of Public Health
Bureau of Infectious Disease
Office of HIV/AIDS
250 Washington Street
Boston, MA 02108
(617) 624-5300

Standards of Care for HIV/AIDS Services

2009

For Acupuncture, Case Management, Client Advocacy, Comprehensive Home-Based Medical Care, Dental Services, Emergency Assistance, Enhanced Medical Management Services, Food and Nutrition, HIV Drug Assistance, Legal Services, Mental Health Services, Peer Support, Primary Medical Care, Residential and Housing Support, Respite Care, Substance Abuse Services, and Transportation

This document can be downloaded from www.bphc.org/aids or www.mass.gov/dph/aids

This project was supported by funding provided by the Boston Public Health Commission through Part A of the Ryan White HIV/AIDS Treatment Modernization Act of 2006, and by the Massachusetts Department of Public Health Office of HIV/AIDS.

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Introduction

The standards of care in this document were developed by the Boston Public Health Commission (BPHC) and the Massachusetts Department of Public Health (MDPH) for HIV/AIDS services funded through each agency. The process to update these standards to include all funded service categories was coordinated by JSI Research and Training Institute, under contract with BPHC, and was conducted by a working group of individuals representing the BPHC and MDPH. These revised standards are based upon the 2004 *Standards of Care for HIV/AIDS Services* which was an initial consolidation of some, but not all, of the existing standards of care into a single set that applied to all providers funded for services through Ryan White Program Part A and B funds and Massachusetts state funds. The 2004 standards were created with the involvement of the Boston EMA HIV Health Services Planning Council, the MA Association of Title II HIV Care Consortia, MDPH, BPHC, and the Boston AIDS Consortium.

These revised standards of care incorporate service categories that were not included in the 2004 document (e.g., case management, comprehensive home-based health care, dental services, enhanced medical management services, legal services, primary medical care, and residential/housing support) and removes some service categories that are no longer funded (e.g., adoption/foster care, day care, drop-in center, and volunteer services). The full list of services covered by these standards is provided below.

The development of these revised and expanded standards of care included the input and feedback of service providers and consumers throughout MA and the Boston Eligible Metropolitan Area (EMA). Draft standards were distributed throughout MA and the Boston EMA in early 2008 with a two week public comment period. All comments were thoroughly reviewed by the working group resulting in some recommended revisions. The final document was reviewed and approved by the BPHC and MDPH.

Section I of the Standards of Care applies to all funded programs and is known as the **Universal Standards of Care**. Each section begins with the objectives of the specific group of standards, and is followed by specific standards and measures. The standards of care in Section I apply to all programs funded by the MDPH and the BPHC for any of the HIV/AIDS services listed below.

- Acupuncture
- Case Management
- Client Advocacy
- Comprehensive Home-Based Medical Care
- Dental Services
- Emergency Assistance
- Enhanced Medical Management Services (EMMS)
- Food and Nutrition
- HIV Drug Assistance
- Legal Services
- Mental Health Services
- Peer Support
- Primary Medical Care
- Residential and Housing Support
- Respite Care
- Substance Abuse Services
- Transportation

In addition to these universal standards, **Section II** contains additional standards that apply to each specific service category. These **Service-specific Standards of Care** apply to components of service delivery that vary by service category. Providers of these services must comply with the Universal Standards in Section I, as well as the Service-Specific Standards in Section II.

The BPHC and MDPH would like to thank those individuals and agencies that contributed their time, energy, and expertise to help revise these standards. Specifically, BPHC and MDPH would like to acknowledge the following individuals who participated in the Standards of Care Workgroup:

- Sharon Asonganyi, Boston Public Health Commission
- Kristin Elifson, Boston Public Health Commission
- Linda Goldman, MDPH Office of HIV/AIDS
- Michael Goldrosen, Boston Public Health Commission
- Paul Goulet, MDPH Office of HIV/AIDS
- Eileen Harrington, Boston Public Health Commission
- Jeremy Holman, JSI Research and Training Institute
- David Lessard, MDPH Office of HIV/AIDS
- Sophie Lewis, MDPH Office of HIV/AIDS
- Charlot Lucien, MDPH Office of HIV/AIDS
- Alison Mehlman, MDPH Office of HIV/AIDS

Section I

Universal Service Standards

Section I: Universal Service Standards

Standards of Care are the minimum requirements that programs are expected to meet when providing HIV/AIDS care and support services funded by Ryan White Part A (through Boston Public Health Commission) or Ryan White Part B and/or MA state funds (through MA Department of Public Health). The standards of care establish the minimum standards intended to help agencies meet the needs of their clients. **Providers may exceed these standards.**

The objectives of the universal service standards are to help achieve the goals of each service type by ensuring that programs:

- have policies and procedures in place to protect clients' rights and ensure quality of care;
- provide clients with access to the highest quality services through experienced, trained and, when appropriate, licensed staff;
- provide services that are culturally and linguistically appropriate;
- meet federal and state requirements regarding safety, sanitation, access, public health, and infection control;
- guarantee client confidentiality, protect client autonomy, and ensure a fair process of grievance review and advocacy;
- comprehensively inform clients of services, establish client eligibility, and collect client information through an intake process;
- effectively assess client needs and encourage informed and active client participation;
- address client needs effectively through coordination of care with appropriate providers and referrals to needed services; and
- are accessible to all people living with HIV in Massachusetts and in three counties of Southern New Hampshire (Hillsborough, Rockingham, and Strafford).

1.0 Agency Policies and Procedures

The objectives of the standards for agency policies and procedures are to:

- guarantee client confidentiality, ensure quality care, and provide a fair process to address clients' grievances;
- ensure client and staff safety and well-being;
- facilitate communication and service delivery; and
- ensure that agencies comply with appropriate state and federal regulations.

All provider agencies offering services must have written policies that address client confidentiality, release of information, client grievance procedures, and eligibility.

Confidentiality assures protection of release of information regarding HIV status, behavioral risk factors, or use of services. Each agency will have a client confidentiality policy that is in accordance with state and federal laws. As part of the confidentiality policy, all agencies will provide a **Release of Information Form** describing under what circumstances client information can be released (name of agency/individual with whom information will be shared, information to be shared, duration of the release consent, and client signature). Clients shall be informed that permission for release of information can be rescinded at any time either verbally or in writing. Releases must be dated and are considered no longer binding after one year. For agencies and information covered by the Health Insurance Portability and Accountability Act (HIPAA), the release of information form must be a HIPAA-compliant disclosure authorization.

As part of the intake process (see *Section 5.0*), information requested on the **Joint HIV/AIDS Client Information Form** must be collected for every client, maintained in the client's file, and submitted to the funder.

Programs must also have a **File Review Consent Form** in which clients grant permission for BPHC or MDPH to review client files on site during site visits. For clients who choose not to sign the client consent form, agencies must be able to code all unique identifying information in accordance with all federal, state, and local laws.

A provider agency **grievance procedure** ensures that clients have recourse if they feel they are being treated in an unfair manner or do not feel they are receiving quality services. Each agency will have a policy identifying the steps a client should follow to file a grievance and how the grievance will be handled. The final step of the grievance policy will include information on how the client may appeal the decision if the client's grievance is not settled to his/her satisfaction within the provider agency.

1.0 Agency Policies and Procedures

Standard		Measure	
1.1	Client confidentiality policy exists.	1.1	Written policy on file at provider agency.
1.2	Grievance procedure exists.	1.2	Written procedure on file at provider agency.
1.3	Agency has eligibility requirements for services, in written form, available upon request.	1.3	Written policy on file at provider agency.
1.4	A complete file for each client exists. All client files are stored in a secure and confidential location, and electronic client files are protected from unauthorized use.	1.4	Files stored in a locked file or cabinet with access limited to appropriate personnel. Electronic files are password protected with access limited to appropriate personnel. Paper copies of all required forms that must be signed by the client and/or provider are in every client's file. Files for discharged clients include all of the data requested on the Joint Client Information Form .
1.5	Client's consent for release of information is determined.	1.5	An up-to-date Release of Information Form exists for each specific request for information and each request is signed and dated by the client. ¹ Each release form indicates the destination of the client's information or from whom information is being requested before the client signs the release.
1.6	Client's consent for on-site file review by funders is determined.	1.6	Signed and dated File Review Consent Form in client's record. Consent forms have an expiration date of one year. In event of refusal of consent, file is coded to remove identifying information in accordance with federal, state, and local laws.
1.7	Agency maintains progress notes of all communication between provider and client. Progress notes indicate service provided and referrals that link clients to needed services. Notes are dated, legible, and in chronological order.	1.7	Progress notes maintained in individual client files.

Continued →

¹ One **Release of Information Form** may be used to track multiple requests and releases from a client. The form must include each specific request, the destination of the information, and the client's signature for each release.

1.8	Crisis management policy exists that addresses, at a minimum, infection control (e.g., needle sticks), mental health crises, and dangerous behaviors by clients or staff.	1.8	Written policy on file at provider agency.
1.9	Policy on universal precautions exists; staff members are trained in universal precautions.	1.9	Written policy on file at provider agency; documentation of staff training in personnel file.
1.10	Policy and procedures exist for handling medical emergencies.	1.10	Policy and procedures on file and posted in visible location at site.
1.11	Agency complies with ADA criteria for programmatic accessibility. In the case of programs with multiple sites offering identical services, at least one of the sites is in compliance with relevant ADA criteria.	1.11	Site visit conducted by funder.
1.12	Agency complies with all applicable state and federal workplace and safety laws and regulations, including fire safety.	1.12	Signed confirmation of compliance with applicable regulations on file.

2.0 Client Rights and Responsibilities

The objectives of establishing minimum standards for client rights and responsibilities are to:

- ensure that services are available to all eligible clients;
- ensure that services are accessible for clients;
- involve consumers of HIV/AIDS services in the design and evaluation of services; and
- inform clients of their rights and responsibilities as consumers of HIV/AIDS services.

HIV/AIDS services funded by BPHC or MDPH must be available to all clients who meet eligibility requirements and must be easily accessible.

A key component of HIV/AIDS service delivery is the historic and continued involvement of consumers in the design and evaluation of services. Substantive client input and feedback must be incorporated into the design and evaluation of HIV/AIDS services funded by BPHC and MDPH; this can be accomplished through a range of mechanisms including consumer advisory boards, participation of consumers in HIV program committees or other planning bodies, and/or other methods that collect information from consumers to help guide and evaluate service delivery (e.g., needs assessments, focus groups, or satisfaction surveys).

The quality of care and quality of life for people living with HIV/AIDS is maximized when consumers are active participants in their own health care and share in health care decisions with their providers. This can be facilitated by ensuring that clients are aware of and understand their rights and responsibilities as consumers of HIV/AIDS services. Providers of HIV/AIDS services funded by BPHC and MDPH must provide all clients with a ***Client Rights and Responsibilities*** document that includes, at a minimum, the agency's confidentiality policy, the agency's expectations of the client, the client's right to file a grievance, the client's right to receive no-cost interpreter services, and the reasons for which a client may be discharged from services, including a due process for involuntary discharge. "Due process" refers to an established, step-by-step process for notifying and warning a client about unacceptable or inappropriate behaviors or actions and allowing the client to respond before discharging them from services. Some behaviors may result in immediate discharge.

Clients are entitled to access their files with some exceptions: agencies are not required to release psychotherapy notes, and if there is information in the file that could adversely affect the client (as determined by a clinician) the agency may withhold that information but should make a summary available to the client. Agencies must provide clients with their policy for file access. The policy must at a minimum address how the client should request a copy of the file (in writing or in person), the time frame for providing a copy of the file (cannot be longer than 30 days), and what information if any can be withheld.

2.0 Client Rights and Responsibilities

Standard	Measure
2.1 Services are available to any individual who meets program eligibility requirements.	2.1 Written eligibility requirements on file; client utilization data made available to funder.
2.2 Programs include input from consumers (and as appropriate, caregivers) in the design and evaluation of service delivery.	2.2 Documentation of meetings of consumer advisory board, or other mechanisms for involving consumers in service planning and evaluation (e.g., satisfaction surveys, needs assessments) in regular reports to funder(s).
2.3 Services are accessible to clients.	2.3 Site visit conducted by funder that includes, but is not limited to, review of hours of operation, location, proximity to transportation, and other accessibility factors.
2.4 Program provides each client a copy of a Client Rights and Responsibilities document that informs him/her of the following: <ul style="list-style-type: none"> the agency's client confidentiality policy; the agency's expectations of the client as a consumer of services; the client's right to file a grievance; the client's right to receive no-cost interpreter services; the reasons for which a client may be discharged from services, including a due process for involuntary discharge. 	2.4 Copy of Client Rights and Responsibilities document is given to client; a copy of the form (or a signature/acknowledgement page) is signed by client and kept in client file.
2.5 Clients have the right to access their file.	2.5 Copy of agency's Client File Access policy is signed by client and kept in client file.

3.0 Personnel

The objectives of the standards of care for personnel are to:

- provide clients with access to the highest quality of care through qualified staff;
- inform staff of their job responsibilities; and
- support staff with training and supervision to enable them to perform their jobs well.

All staff and supervisors will be given and will sign a written job description with specific minimum requirements for their position. Agencies are responsible for providing staff with supervision and training to develop capacities needed for effective job performance. At a minimum, all staff should be able to provide appropriate care to clients infected/affected by HIV/AIDS, be able to complete all documentation required by their position, and have previous experience (or a plan for acquiring experience) in the appropriate service/treatment modality (for clinical staff). Clinical staff must be licensed or registered as required for the services they provide. **See the attached service specific standards for additional competencies for some service categories.**

Staff and program supervisors will receive consistent administrative supervision (minimum of one hour per month). Administrative supervision addresses issues related to staffing, policy, client documentation, reimbursement, scheduling, training, quality enhancement activities, and the overall operation of the program and/or agency. In addition to administrative supervision, clinical staff will also receive consistent clinical supervision (minimum of one hour per month). Clinical supervision addresses any issue directly related to client care and job related stress (e.g., boundaries, crises, and burnout). Staff in need of clinical supervision must have two separate supervisors for clinical and administrative supervision.

3.0 Personnel

Standard	Measure
3.1 Staff members have the minimum qualifications expected for their job position, as well as other experience related to the position and the communities served.	3.1 Résumé in personnel file meeting the minimum requirements of the job description.
3.2 Staff members are licensed as necessary to provide services.	3.2 Copy of license or other documentation in personnel file.
3.3 Staff and supervisors know the requirements of their job description and the service elements of the program.	3.3 Documentation in personnel file that each staff members received job description.
3.4 Newly hired staff are oriented within 6 weeks, and begin initial training within 3 months of being hired. Ongoing training continues throughout staff's tenure.	3.4 Documentation in personnel file of (a) completed orientation within 6 weeks of date of hire; (b) commencement of initial training within 3 months of date of hire; and (c) ongoing trainings.
3.5 Staff receive at least one hour of administrative supervision per month, and when required, at least one hour of clinical supervision per month. Administrative and clinical supervision is conducted by separate individuals.	3.5 Signed documentation on file indicating the date of supervision, type of supervision (administrative or clinical), and name of supervisor.

4.0 Cultural and Linguistic Competence

The objective for establishing standards of care for cultural and linguistic competence is to provide services that are culturally and linguistically appropriate.

Culture is the integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, and values of individuals and groups, all which may be influenced by race, ethnicity, religion, class, age, gender, gender identity, disability, sexual orientation, and other aspects of life upon which people construct their identities. In our work with people living with HIV, culture may also include past or current substance use, homelessness, mental health, and/or incarceration, among others.

Cultural competence is a set of behaviors, attitudes, and policies that come together in a system, agency, or among individuals that enables effective delivery of services. **Linguistic competence** is the ability to communicate effectively with clients, including those whose preferred language is not the same as the provider's, those who are illiterate or have low literacy skills, and/or those with disabilities. Cultural and linguistic competence is a goal toward which all providers must aspire, but one that may never be completely achieved given the diversity of languages and cultures throughout our communities. However, all providers should be involved in a continual process of learning, personal growth, experience, education, and training that increases cultural and linguistic competence and enhances the ability to provide culturally and linguistically appropriate services to all individuals living with HIV/AIDS. **Culturally and linguistically appropriate services** are services that:

- respect, relate, and respond to a client's culture, in a non-judgmental, respectful, and supportive manner;
- are affirming and humane, and rely on staffing patterns that match the needs and reflect the culture and language of the communities being served;
- recognize the power differential that exists between the provider and the client and seek to create a more equal field of interaction; and
- are based on individualized assessment and stated client preferences rather than assumptions based on perceived or actual membership in any group or class.

As part of the on-going process of building cultural and linguistic competence, providers should strive to develop:

- a comfort with and appreciation of cultural and linguistic difference;
- interpersonal behaviors that demonstrate and convey concern and respect for all cultures;
- the comfort and ability to acknowledge the limits of personal cultural and linguistic competence and the skills to elicit, learn from, and respond constructively to relevant personal and cultural issues during service interactions; and
- a commitment to increasing personal knowledge about the impact of culture on health and specific knowledge about the communities being served.

Ongoing trainings that help build cultural and linguistic competence may include traditional cultural and linguistic competency trainings, as well as a range of trainings that help build specific skills and knowledge to work and communicate more effectively with the communities we serve.

4.0 Cultural and Linguistic Competence

Standard	Measure
<p>4.1 Programs recruit, retain, and promote a diverse staff that reflects the cultural and linguistic diversity of the community.</p> <p>4.2 All staff receive on-going training and education to build cultural and linguistic competence and/or deliver culturally and linguistically appropriate services.</p> <p>4.3 Programs assess the cultural and linguistic needs, resources, and assets of its service area and target population(s).</p> <p>4.4 Programs' physical environment and facilities are welcoming and comfortable for the populations served.</p> <p>4.5 All programs ensure access to services for clients with limited English skills in one of the following ways (listed in order of preference):</p> <ul style="list-style-type: none"> • Bilingual staff who can communicate directly with clients in preferred language; • Face-to face interpretation² provided by qualified staff, contract interpreters, or volunteer interpreters; • Telephone interpreter services (for emergency needs or for infrequently encountered languages); or • Referral to programs with bilingual/bicultural clinical, administrative and support staff and/or interpretation services by a qualified bilingual/bicultural interpreter. 	<p>4.1 Programs have a strategy on file to recruit, retain and promote qualified, diverse, and linguistically and culturally competent administrative, clinical, and support staff who are trained and qualified to address the needs of people living with HIV/AIDS.</p> <p>4.2 All staff members receive appropriate training within the first year of employment and periodically thereafter as needed. Copies of training verification in personnel file.</p> <p>4.3 Programs collect and use demographic, epidemiological, and service utilization data in service planning for target population(s).</p> <p>4.4 Funder site visit.</p> <p>4.5 Programs document access to services for clients with limited English skills through the following:</p> <ul style="list-style-type: none"> • For bilingual staff, résumés on file demonstrating bilingual proficiency and documentation on file of training on the skills and ethics of interpreting; • Copy of certifications on file for contract or volunteer interpreters; • Listings/directories on file for telephone interpreter services; or • Listings/directories on file for referring clients to programs with bilingual/bicultural clinical, administrative and support staff, and/or interpretation services by a qualified bilingual/bicultural interpreter.

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² **Interpretation** refers to verbal communication that translates speech from a speaker to a receiver in a language that the receiver can understand. **Translation** refers to the conversion of written material from one language to another.

4.0 Cultural and Linguistic Competence (continued)

4.6	Clients are informed of their right to obtain no-cost interpreter services in their preferred language, including ASL.	4.6	Client Rights and Responsibilities document includes notice of right to obtain no-cost interpreter services (see Universal Standard 2.4).
4.7	Family and friends are not considered adequate substitutes for interpreters because of privacy, confidentiality, and medical terminology issues. If a client chooses to have a family member or friend as their interpreter, the provider obtains a written and signed consent in the client's language. Family member or friend must be over the age of 18.	4.7	Family/friend interpretation consent form signed by client and maintained in client file.
4.8	Clients have access to linguistically appropriate signage and educational materials.	4.8	<p>Programs provide commonly used educational materials and other required documents (e.g., grievance procedures, release of information, rights and responsibilities, consent forms, etc.) in the threshold language of all threshold populations.³</p> <p>Programs that do not have threshold populations have a documented plan for explaining appropriate documents and conveying information to those with limited English proficiency.</p>
4.9	Programs conduct on-going assessments of the program and staff's cultural and linguistic competence.	4.9	Programs integrate cultural competence measures into program and staff assessments (e.g., internal audits, performance improvement programs, patient satisfaction surveys, personnel evaluations, and/or outcome evaluations).

³ A **threshold population** is a linguistic group that makes up 15% or more of a program's clients and who share a common language other than English as a primary language. For example, if program XYZ serves 200 clients and at least 30 of them speak Haitian-Creole as a primary language, that group would be considered a threshold population for that program and Haitian-Creole would be considered a **threshold language**. Some programs may target multiple groups, and therefore, may have multiple threshold populations and threshold languages; some programs may have no threshold populations.

5.0 Intake and Eligibility

The objectives of the standards for the intake process are to:

- assess client's immediate needs;
- inform the client of the services available and what the client can expect if s/he were to enroll;
- establish the client's eligibility for services, including HIV status and other criteria;
- establish whether the client wishes to enroll in a range of services or is interested only in a discrete service offered by the provider agency;
- explain the agency policies and procedures;
- collect required state/federal client data for reporting purposes;
- collect basic client information to facilitate client identification and client follow up; and
- begin to establish a trusting client relationship.

All clients who request or are referred to HIV services will participate in the **intake process**. Intake is conducted by an appropriately trained program staff or intake worker. The intake worker will review client rights and responsibilities, explain the program and services to the client, explain the agency's confidentiality and grievance policies to the client, assess the client's immediate service needs, and secure permission from the client to release information (if there is an immediate need to release information). The intake must include the **Joint HIV/AIDS Client Information Form** (required by BPHC and MDPH) and any other service specific information that pertains to the program.

Intake is considered complete if the following have been accomplished: (1) the client's HIV positive status has been verified and documented; (2) the **Joint HIV/AIDS Client Information Form** has been completed, and (3) the information below (at a minimum) has been obtained from the client:

- name, address, social security number, phone, and email (if available);
- preferred method of communication (e.g., phone, email, or mail);
- emergency contact information;
- preferred language of communication;
- enrollment in other HIV/AIDS services including case management and other HIV/AIDS or social services;
- primary reasons and need for seeking services at agency.

A client who chooses to enroll in services and who is eligible will be assigned a staff member who is responsible for making contact with the client to set up a time for a more thorough assessment, if necessary, to determine appropriate services. Referrals for other appropriate services will be made if ineligible. The intake process will begin within five days of the first client contact with the agency. Ideally, the client intake process should be completed as quickly as possible; however, recognizing that clients may not have on hand the required documentation (e.g., documentation of HIV status), the intake process should be completed within 30 days of beginning intake.

5.0 Intake and Eligibility

Standard	Measure
5.1 Intake process is completed within 30 days of initial contact with client and documents client's contact information (including his/her emergency contact's name and phone number) and assesses his/her immediate service needs and connection to primary care and other services.	5.1 Completed intake, dated no more than 30 days after initial contact, in client's file.
5.2 For providers of services other than case management, client is asked about connection to case management. If client is not connected to case management, provider facilitates a supported referral to case management services.	5.2 Documentation in client's file.
5.3 To determine minimum eligibility for services, client's HIV-positive status is verified if client chooses to enroll.	5.3 Physician's note or laboratory test in client's file documenting that client is HIV- positive.

6.0 Assessment and Service Plan

The objectives of the standards for assessment and service plan are to:

- gather information to determine the client's needs;
- identify the client's goals and develop action steps to meet them;
- identify a timeline and responsible parties for meeting the client's goals; and
- ensure coordination of care with appropriate providers and referral to needed services.

Assessment

All providers must assess the client's needs for the provider's service(s) to develop an appropriate service plan. This is **not** the same as the comprehensive *case management* assessment, which is the responsibility of the client's case manager (see service-specific standards for Case Management Services) in collaboration with the client.

Service assessments include an assessment of all issues that may affect the need for the provider service. The assessment is a cooperative and interactive endeavor between the staff and the client. The client will be the primary source of information. However, with client consent, assessments may include additional information from case manager(s), medical or psychosocial providers, caregivers, family members, and other sources of information, if the client grants permission to access these sources. The assessment should be conducted face-to-face within 30 days of intake, with accommodations for clients who are too sick to attend the appointment at the provider agency.

It is the responsibility of the staff to reassess the client's needs with the client as his/her needs change. The reassessment should be done as needed, but no less than once every six (6) months. If a client's income, housing status, or insurance status/resource has changed since assessment or the most recent reassessment, agencies must ensure that the data on the Joint Client Information Form is updated accordingly and that it is submitted to the funder. The staff member is encouraged to contact other service providers/care givers involved with the client or family system in support of the client's well being. Staff members must comply with established agency confidentiality policies (see Standard 1.1) when engaging in information and coordination activities.

Individual Service Plan (ISP)

The purpose of the **individual service plan (ISP)** is to guide the provider and client in their collaborative effort to deliver high quality care corresponding to the client's level of need. It should include short-term and long-term goals, based upon the needs identified in the assessment, and action steps needed to address each goal. The ISP should include specific services needed and referrals to be made, including clear time frames and an agreed upon plan for follow up.

As with the assessment process, service planning is an on-going process. It is the responsibility of the staff to review and revise a client's ISP as needed, but not less than once every six (6) months.

As part of the ISP, programs must ensure the coordination of services. Coordination of services requires identification of other staff or service providers with whom the client may be working. As appropriate and with client consent, program staff will act as a liaison among clients, caregivers, and other service providers to obtain and share information that supports optimal care and service provision. If a program is unable to provide a specific service, it must be able to make immediate and

effective referrals. In case of referrals, staff must facilitate the scheduling of appointments, transportation, and the transfer of related information.

6.0 Assessment and Service Plan	
Standard ^{4, 5}	Measure ^{4,5}
6.1 Within 30 days of client contact, assessment is conducted of client's need for particular service. ⁶	6.1 Completed assessment form in the client file.
6.2 Within 30 days of client contact, ISP is developed collaboratively with the client that identifies goals and objectives, resources to address client's needs, and a timeline.	6.2 Completed ISP in client file signed by the client and staff person.
6.3 Reassessment of the client's needs is conducted as needed, but not less than once every six months. ^{7,8}	6.3 Documentation of reassessment in the client files (e.g., progress notes, update notes on the initial assessment, or new assessment form).
6.4 Service plan is reviewed and revised as needed, but not less than once every six months. ⁶	6.4 Documentation of ISP review/revision in client's file (e.g., progress notes, update notes on initial ISP, or new ISP). Updated ISP shall be signed by client, staff person, and supervisor.
6.5 Program staff identify and communicate as appropriate (with documented consent of client) with other service providers to support coordination and delivery of high quality care and to prevent duplication of services.	6.5 Documentation in client file of other staff within the agency or at another agency with whom the client may be working.

⁴ **DENTAL SERVICES** providers are exempt from compliance with Universal Standards 6.1 thru 6.5, but must comply with the Dental Service-specific Standards for treatment assessment and planning.

⁵ **CASE MANAGEMENT SERVICES** providers are exempt from compliance with Universal Standards 6.1 thru 6.5, but must comply with the Case Management Service-specific Standards for assessment and service planning.

⁶ For **COMPREHENSIVE HOME-BASED MEDICAL CARE** providers, intake must be completed within 72 hours of referral. See the Comprehensive Home-Based Medical Care Service-specific Standards for intake and eligibility requirements.

⁷ For **EMMS** providers, reassessment and treatment plan revisions must occur at least every four months. See the EMMS Service-Specific Standards for assessment and service planning requirements.

⁸ For **RESIDENTIAL/HOUSING SUPPORT SERVICES** providers that provide congregate, supportive housing services, reassessments must be conducted during face-to-face meetings between clients and case managers. See the Residential/Housing Support Service-specific Standards, Section II, D for assessment and service plan requirements.

7.0 Transition and Discharge

The objectives of the standards for transition and discharge are to:

- ensure a smooth transition for clients who no longer want or need services at the provider agency;
- maintain contact with active clients and identify inactive clients;
- assist provider agencies in more easily monitoring caseload; and
- plan after-care and re-entry into service.

A client may be discharged from any service through a systematic process that includes a discharge summary in the client's record. The discharge summary will include a reason for the discharge and a transition plan to other services or other provider agencies, if applicable. Agencies should maintain a list of available resources available for the client for referral purposes. If the client does not agree with the reason for discharge, (s)he should be referred to the provider agency's grievance procedure.

A client may be discharged from any service for any of the following reasons:

- client dies;
- client requests a discharge;
- client's needs change and (s)he would be better served through services at another provider agency;
- client's actions put the agency, service provider, or other clients at risk;
- client sells or exchanges emergency assistance, child care, or transportation vouchers for cash or other resource for which the assistance is not intended;
- client moves/relocates out of the service area; or
- the agency is unable to reach a client, after repeated attempts, for a period of 12 months.

7.0 Transition and Discharge

Standard	Measure
7.1 Agency has a transition and discharge procedure in place that is implemented for clients leaving or discharged from services for any of the reasons listed in the narrative above.	7.1 Completed transition/discharge summary form on file, signed by client (if possible) and supervisor. Summary form should include: <ul style="list-style-type: none"> • reason for discharge; and • a plan for transition to other services, if applicable, with confirmation of communication between referring and referral agencies, or between client and agency.
7.2 Agency has a due process policy in place for involuntary discharge of clients from services; policy includes a series of verbal and written warnings before final notice and discharge.	7.2 Due process policy on file as part of transition and discharge procedure; due process policy described in the <i>Client Rights and Responsibilities</i> document (see Universal Standard 2.4).
7.3 Agency has a process for maintaining communication with clients who are active and identifying those who are inactive.	7.3 Documentation of agency process for maintaining communication with active clients and identifying inactive clients.
7.4 Agency provides clients with referral information to other services, as appropriate.	7.4 Resource directories or other material on HIV related services are on file and provided to clients.

Section II

Service-Specific Standards

Section II: Service-Specific Standards

In addition to the Universal Standards of Care, providers of services must also meet additional standards that are specific to certain services. This section contains standards of care specific to the following services:

- Acupuncture
- Case Management
- Client Advocacy
- Comprehensive Home-Based Medical Care
- Dental Services
- Emergency Assistance
- Enhanced Medical Management Services (EMMS)
- Food and Nutrition
- HIV Drug Assistance
- Legal Services
- Mental Health Services
- Peer Support
- Primary Medical Care
- Residential and Housing Support
- Respite Care
- Substance Abuse Services
- Transportation

If you are a provider of any of the above services, your program must meet both the Universal and Service Specific Standards of Care.

Acupuncture

Acupuncture Service Definition

Services funded under this category include therapeutic treatments provided by a licensed acupuncturist that involves the use of sterile, disposable acupuncture needles inserted in clients for the purpose of assisting them with adherence, symptom management, and health care.

Acupuncture Standards of Care

The overall objectives of the Acupuncture standards of care are to:

- ensure that all clients have been referred by their primary health care provider as required by federal and state regulations (or substance abuse counselor in the case of referrals for acupuncture associated with substance abuse treatment); and
- protect the health and well-being of clients and staff.

The service specific standards of care for **Acupuncture** provide additional requirements on the following components of service provision:

A. Intake

B. Agency Licensing and Policies

Acupuncture providers are expected to comply with the Universal Standards of Care, as well as these additional standards.

A. Intake

The objective of the intake standard for **Acupuncture** is to ensure that clients have been referred to services by a primary care physician, as required by federal and state regulations.

A. Intake		Complementary/Holistic Therapies	
Standard		Measure	
A.1	Clients who use acupuncture services have been referred by a primary care physician, as required by federal and state regulations.	A.1	Documentation of referral from primary care physician in client's record.

B. Agency Licensing and Policies

The objective of the agency licensing and policies standards for **Acupuncture** is to protect the health and well-being of clients and staff.

B. Agency Licensing and Policies		Acupuncture	
Standard		Measure	
B.1	Clinical staff providing acupuncture services have appropriate professional liability coverage.	B.1	Documentation of malpractice insurance (in good standing) on file at provider agency.
B.2	Agency complies with standards for materials purchase, storage, use, count, and disposal.	B.2	All acupuncture needles are sterile and prepackaged, used once, and disposed of according to biohazard standards. Agencies have a documented procedure in place to ensure needle count on insertion and removal.

Case Management

Case Management Service Definition

HIV/AIDS case management consists of client-centered services that link clients with health care and psychosocial support services in a manner that ensures timely, coordinated access to appropriate levels of care commensurate with the client's needs. Case management may include the coordination and follow-up of medical treatment and the provision of treatment adherence counseling. Activities include assessment of the client's needs and personal support systems; development of a comprehensive individualized service plan that includes access to public and private benefits, as applicable; coordination of the services required to implement the plan; monitoring of the client's progress to assess the efficacy of the plan; and periodic reevaluation and revision of the plan as the needs of the client change over time. Case management also promotes the prevention of HIV transmission, sexually transmitted infections (STIs), and viral hepatitis.

The ultimate goal of case management is to help clients enter into and remain in primary care. In the process, programs must facilitate each client's progress toward self-sufficiency.

Case Management Standards of Care

The overall objectives of the Case Management standards of care are to:

- provide the highest quality of care through experienced and trained case managers;
- gather information to assess and determine each client's needs; and
- develop and implement a service plan.

The service specific standards of care for **Case Management** provide additional requirements on the following components of service provision:

- A. **Agency Policies and Procedures**
- B. **Competencies**
- C. **Assessment and Service Planning**

Case Management providers are expected to comply with the Universal Standards of Care (except as noted below), as well as these additional standards.

EXCLUSION: Case Management providers *are not required to adhere to Universal Standards 6.1 thru 6.5 (assessment and service planning), but must comply with the service specific assessment and service planning standards below (C.1 thru C.3).*

A. Agency Policies and Procedures

The objective of the agency policies and procedures standards for **Case Management** is to ensure that case managers have appropriate caseloads.

A. Agency Policies and Procedures		Case Management	
Standard		Measure	
A.1	Case managers (1.0 FTE) have a minimum of twenty-five (25) active clients.	A.1	Files exist for at least twenty-five (25) active clients for each 1.0 FTE case manager. Written justification for any caseload size of less than twenty-five (25) clients per 1.0 FTE case manager must be on file at the agency.
A.2	Case management supervisor conducts a file review every six months to ensure that client files meet standards.	A.2	Documentation in client's file or separate location (e.g., binder).

B. Competencies

The objectives of the competencies standards for **Case Management** are to:

- provide the highest quality of care through experienced and trained case managers;
- provide case managers with quality supervision; and
- inform case managers/case management supervisors of their job responsibilities.

HIV case managers must be able to work with clients and develop a supportive relationship, enable clients to reach their self-sufficiency goals, and facilitate access to and use of available services. At a minimum, all case managers hired by provider agencies will be able to demonstrate the ability to coordinate services, information and referrals for clients in need of case management services, the ability to complete documentation as required by their position, and previous experience in the human service delivery field. All HIV case managers and case manager supervisors will be given a written job description that outlines specific minimum qualifications. Once hired, case managers must participate in the MDPH case manager training within three months of being hired.

B. Competencies		Case Management	
Standard		Measure	
B.1	Newly hired HIV case managers have at least the following qualifications: <ul style="list-style-type: none">• the ability to coordinate services, information, and referrals for clients in need of HIV related medical and support services;• the ability to complete documentation required by the case management position; and• experience and/or education consistent with the job description.	B.1	Job description on file that describes minimum qualifications of standard. Résumé in personnel file meeting minimum requirements of the job description.
B.2	Newly hired or promoted HIV case manager supervisors have at least the minimum qualifications described above for case managers plus two years of case management experience or other experience relevant to the position (e.g., volunteer management).	B.2	Résumé in personnel file meeting minimum requirements of standard.
B.3	Newly hired case managers attend funder-sponsored case management training within three months of being hired, as well as other trainings on risk assessment and positive prevention.	B.3	Documentation of completed training on file.

C. Assessment and Service Planning

The objectives of the assessment and service planning standards for **Case Management** are to:

- gather appropriate information from each client at regular intervals to determine and assess his/her needs; and
- develop, implement, and monitor a service plan collaboratively with each client, including action steps and a timeline for meeting his/her goals based on his/her needs.

A client has a right to a fair and comprehensive assessment of his/her medical and support service needs. The focus of the **initial assessment** is to evaluate client needs through a cooperative and interactive process involving the case manager and the client. The client will be the primary source of information, but information from other sources (e.g., family members, or medical and psychosocial providers) may be included if the client grants permission to access these sources. The initial assessment should be conducted face-to-face and at a location that is mutually acceptable to the client and the case manager (including the client's home or in the hospital if the client is too sick to travel to the agency). The assessment may occur at intake, but must be completed within 60 days of intake.

A **Case Management Assessment Form** has been created by MDPH and BPHC and can be accessed at www.bphc.org/aids. Agencies may use their own form, but assessments must address at minimum the following components:

- | | |
|--------------------------------------|--------------------------------|
| • Basic information about the client | • Financial and legal concerns |
| • Connection to medical care | • Access to nutritious food |
| • Health status | • Mental health |
| • Access to benefits | • Sexual health/positive |
| • Support systems and relationships | • prevention/partner services |
| • Housing | • Substance use |
| | • Overall level of need |

During the initial assessment, each client must be assessed for linkages to primary care and screened for basic substance abuse or mental health issues. If the assessment indicates a possible need for substance abuse treatment and/or mental health services, the client will be referred to a qualified substance abuse counselor and/or mental health clinician for a comprehensive clinical assessment.

Based on the information collected during the intake and initial assessment, the case manager will create a customized **individual service plan/client action plan (ISP/CAP)** with the client. The ISP/CAP serves as the road map for the client's progress through the HIV service system and will include measureable goals and objectives that encourage client self-sufficiency. The ISP/CAP should include specific services needed and referrals to be made including time frames and a plan for follow-up. The ISP/CAP must address harm reduction and positive prevention. ISP/CAP must be completed within 60 days of the initial intake date and must be reviewed and approved by the case management supervisor.

Assessment and service planning are ongoing processes. It is the responsibility of the case manager to reassess a client's needs and his/her ISP/CAP as needed but no less than once every six (6) months.

C. Assessment and Service Planning		Case Management	
Standard		Measure	
C.1	Comprehensive initial assessment is completed within 60 days of intake, including: <ul style="list-style-type: none"> • basic information about the client; • support systems and relationships; • connection to medical care; • health status; • housing; • financial and legal concerns; • access to nutritious food; • mental health; • sexual health/positive prevention/partner services; • substance use; • overall level of need. 	C.1	Completed case management assessment form in the client file.
C.2	Individual service plan/client action plan (ISP/CAP) is completed collaboratively with the client within 60 days of intake and includes short-term and long-term goals, action steps to address each goal, specific services needed and referrals to be made, barriers and challenges, a timeline, and a plan for follow-up.	C.2	In addition to having the client's and case manager's signature, a completed ISP/CAP is reviewed, approved, and signed by the case management supervisor and stored in client's file.
C.3	Reassessment of client needs is completed as needed, but not less than once every six months. At least once per year, re-assessment must be conducted face-to-face.	C.3	Documentation of reassessment in client's file, including whether the re-assessment was conducted over the phone or face-to-face.

Client Advocacy

Client Advocacy Service Definition

Services funded under this category provide short-term specialized assistance to clients throughout the process of accessing and obtaining financial and legal services that include, but which are not limited to healthcare benefits, immigration, social security, and disability benefits.

There are no service specific standards of care for Client Advocacy services. Please refer to the Universal Standards for the required standards for this service.

Comprehensive Home-Based Medical Care

Comprehensive Home-Based Medical Care Definition

Services funded under this category assist persons living with HIV/AIDS to receive home-based nursing, homemaking assistance, and Life Skills Advocacy (LSA) services. Practical support, adherence assistance, mental health care, preventative, and supportive care help patients successfully remain in the community and avoid unnecessary hospitalizations, opportunistic infections, and general decline in health status. This model of care allows professional nursing and paraprofessional staff to incorporate multiple modalities of care into one service plan, providing comprehensive care for individuals living with HIV, their partners, and families. The LSA program supports trained staff to provide home-based social services in partnership with the client's primary care clinician, home health nurse, and family (when appropriate), including independent activities of daily living. All components of the Home-Based Medical Care program are integrated within a positive prevention and harm reduction approach via regular assessment of behavioral risks that may include sexual and drug injection partners.

Key activities of this service include assessment and treatment planning, adherence support, engagement and retention in care, coordination of medical care services, support with health insurance, and medication coverage.

Comprehensive Home-Based Medical Care Standards of Care

The overall objectives of the Comprehensive Home-Based Medical Care standards of care are to ensure that patients receive quality home-based clinical, non-clinical, and adherence counseling services.

The service specific standards of care for **Comprehensive Home-Based Medical Care** provide additional requirements on the following components of service provision:

- A. Personnel
- B. Intake and Eligibility
- C. Transition and Discharge

Comprehensive Home-Based Medical Care providers are expected to comply with the Universal Standards of Care (except as noted below), as well as these additional standards.

EXCLUSION: Comprehensive Home-Based Medical Care providers *are exempt from Universal Standard 6.1, but must comply instead with the service-specific intake and eligibility standard below (B.1).*

A. Personnel

The objective of the personnel standard of care for **Comprehensive Home-Based Medical Care** is to promote high quality care by ensuring that services are provided by Home Health Nurses who have appropriate licenses and are credentialed to perform nursing responsibilities.

A. Personnel		Comprehensive Home-Based Medical Care	
Standard		Measure	
A.1	Nursing services are provided by Home Health Nurses who are credentialed and by licensed Registered Nurses (unless otherwise approved by HAB Health Services Director and Home Health Program Manager).	A.1	Résumé and documentation of licensure for each staff member funded to provide services in personnel files at the agency.
A.2	Homemaker services are provided by a licensed or otherwise credentialed agency or staff person, either directly or via subcontract.	A.2	Résumé and documentation of licensure for each staff member funded to provide services in personnel files at the agency.

B. Intake and Eligibility

The objective of the intake and eligibility standards of care for **Comprehensive Home-Based Medical Care** is to ensure that initial patient assessments are completed in a timely manner.

B. Intake and Eligibility		Comprehensive Home-Based Medical Care	
Standard		Measure	
B.1	An initial assessment is conducted within 72 hours of referral.	B.1	Completed assessment form in client file with documentation of date of referral and assessment completion.

C. Transition and Discharge

The objective of the transition and discharge standard of care for **Comprehensive Home-Based Medical Care** is to ensure that staff support a smooth transition for patients who are discharged to home after a period of hospitalization and that they collaborate with staff at inpatient facilities to ensure the patient's needs are met.

C. Transition and Discharge		Comprehensive Home-Based Medical Care	
Standard		Measure	
C.1	Staff actively participate in the patient's inpatient discharge planning and collaborate with the local EMMS provider and local inpatient facilities that share mutual patients.	C.1	Current memoranda of agreement (MOAs) with discharge planning teams at community inpatient facilities are on file at the agency.

Dental Services

Dental Services Definition

Services funded under this category are the recruitment of dentists and preventive diagnostic and therapeutic services rendered by dentists, dental hygienists, and other dental practitioners.

Dental Services Standards of Care

The overall objectives of the standards of care for Dental Services are to:

- provide access to treatment by licensed dentists;
- appropriately address issues of consent and confidentiality for a client enrolled in services; and
- deliver high quality services corresponding to a client's level of need.

The service specific standards of care for **Dental Services** provide additional requirements on the following components of service provision:

- A. Competencies
- B. Client Rights and Responsibilities
- C. Treatment Assessment and Planning

Dental Services providers are expected to comply with the Universal Standards of Care (except as noted below), as well as these additional standards.

EXCLUSION: Dental Services providers *are not required* to adhere to Universal Standards 6.1 thru 6.5 (assessment and service planning), but must comply with the service specific treatment assessment and planning below (C.1 and C.2).

A. Competencies

The objective of the competencies standards for **Dental Services** is to provide clients with the highest quality services through trained, experienced, and appropriately licensed and credentialed staff members.

A. Competencies		Dental Services	
Standard		Measure	
A.1	Participating dentists possess appropriate license, credentials, and expertise.	A.1	Completed forms in provider's personnel files; forms contain Board of Dentistry license number.
A.2	The program director has training and experience in clinical aspects of oral hygiene, dental treatment planning, and dental care.	A.2	Résumé in provider's personnel files.

B. Client Rights and Responsibilities

The objectives of the client rights and responsibilities standards for **Dental Services** are to:

- incorporate a client's input into the treatment plan; and
- provide a fair process for review if a client believes (s)he has been mistreated, poorly served, or wrongly discharged from services.

B. Client Rights and Responsibilities		Dental Services	
Standard		Measure	
B.1	Program has written policy regarding wait list of eligible prospective clients.	B.1	Written policy on file with BPHC or MDPH.
B.2	Program ensures that treatment is provided with the written consent of the client.	B.2	Dentist has signed contract with HIV Dental Program including a statement that clients will provide written consent for treatment.
B.3	Program has an appeal process in place in the event a client's treatment plan is not approved.	B.3	Written policy and procedures in provider's files.
B.4	Program has policies and procedures to address client complaints of discrimination by participating dentists.	B.4	Written policy in provider's files regarding notification of State Board of Dentistry in cases of reported discrimination.

C. Treatment Assessment and Planning

The objective of the treatment assessment and planning standards for **Dental Services** is to guide the provider in delivering high quality care corresponding to the client's level of need.

C. Treatment Assessment and Planning		Dental Services	
Standard		Measure	
C.1	A treatment plan is developed based upon the initial examination of the client.	C.1	Completed treatment plan in client file at the provider, submitted by dentist, and reviewed and approved by dental program director.
C.2	Treatment plan is reviewed and updated as deemed necessary by the dental provider or dental program director.	C.2	Updated treatment plan in client file at the provider, submitted by dentist, and revised and approved by dental program director.

Emergency Assistance

Emergency Assistance

Services funded under this category consist of short-term financial assistance to help clients meet emergency needs when all other options have been exhausted. Emergency assistance services are limited to assistance with transportation, food, housing (including essential utilities), and medication. Emergency assistance may *not* be provided to clients in cash or cash equivalents (such as traveler's checks or gift cards that are not provided by a vendor offering an emergency assistance service) with the exception of mileage reimbursement which must be documented in accordance with the agency's mileage reimbursement policy.

Emergency Assistance Standards of Care

The overall objective of the Emergency Assistance standards of care is to provide services to eligible clients with the greatest need.

The service specific standards of care for **Emergency Assistance** provide additional requirements on the following components of service provision:

A. Agency Policies

Emergency Assistance providers are expected to comply with the Universal Standards of Care, as well as these additional standards.

A. Agency Policies

The objective of the agency policies standard for **Emergency Assistance** is to provide services to eligible clients with the greatest need.

A. Agency Policies		Emergency Assistance	
Standard		Measure	
A.1	Eligibility is restricted by income, and budget management activities are offered.	A.1	Proof of monthly income on file, and documentation of offer of budget management assistance.
A.2	Agency has written protocol for distribution of funds that defines eligibility, frequency of service receipt, and maximum benefits. Protocol must also include documentation of service delivery.	A.2	Written protocol on file at agency.

Enhanced Medical Management Services (EMMS)

Enhanced Medical Management Services (EMMS) Definition

Enhanced Medical Management Services (EMMS) are funded in clinical sites that provide comprehensive primary and specialty medical care for persons living with HIV/AIDS. The program supports clinical staff to provide medical management that is integrated with an adherence program. Nurse Medical Managers act as navigators and advocates to assist patients through the complex medical structure and help insure that patients receive timely and appropriate health care services. Nurse medical managers help coordinate medical treatment by providing inter- or intra-agency supported referrals, convening case conferences, and ensuring that information regarding patient service needs is shared across members of the patient's care team. Adherence Counselors focus on the immediate and long-term impacts that medications have in influencing patient health and quality of life. Both components are fully integrated within a positive prevention and harm reduction approach via regular assessments of behavioral risks that may also include sexual and drug injection partners.

Key activities of EMMS include assessment and treatment planning, adherence support, engagement and retention in care, coordination and follow-up of medical care services, and support with health insurance and medication coverage.

EMMS Standards of Care

The overall objective of the EMMS standards of care is to ensure that patients receive quality medical management, non-clinical medical management, and adherence counseling services.

The service specific standards of care for **EMMS** provide additional requirements on the following components of service provision:

- A. Personnel
- B. Assessment and Service Planning
- C. Transition and Discharge

EMMS providers are expected to comply with the Universal Standards of Care (except as noted below), as well as these additional standards.

EXCLUSION: EMMS providers *are exempt from* Universal Standard 6.3 and 6.4, but must comply instead with the service-specific assessment and service planning standards below (B.1 and B.2).

A. Personnel

The objective of the personnel standards for **EMMS** is to promote high quality care by ensuring medical managers are appropriately licensed and credentialed to perform nursing responsibilities.

A. Personnel		EMMS
Standard	Measure	
A.1 The functions of Nurse Medical Manager and Adherence Counselor are performed by credentialed and licensed Registered Nurses.	A.1 Résumés and documentation of licensure in personnel files at the agency.	

B. Assessment and Service Plan

The objective of the assessment and service planning standard for **EMMS** is to ensure that a review of the patient's medical and psychosocial needs is conducted to address barriers to care management, adherence, or health promotion.

B. Assessment and Service Planning		EMMS
Standard	Measure	
B.1 Nurse Medical Manager re-assesses patient needs and makes amendments to the individual care plan as needed but not less than once every four months.	B.1 Completed assessment form in the client file. Completed individual care plan in client file signed and dated by the client and staff person. Documentation of reassessment in the client files (e.g., progress notes, updated notes on the initial assessment, or new assessment form).	
B.2 Nurse Medical Manager identifies and communicates as appropriate (with documented consent of client) with other medical treatment providers to support coordination and delivery of high quality care.	B.2 Documentation in client file of communication with other medical treatment providers who provide care to the client.	

C. Transition and Discharge

The objective of the transition and discharge standard for **EMMS** is to ensure a smooth transition for clients who are discharged from an inpatient setting after a period of hospitalization, or for patients who elect to transfer their care due to relocation or other circumstances.

C. Transition and Discharge		EMMS
Standard		Measure
C.1	Staff actively participate in patient discharge planning process.	C.1 Transition plan is documented in the medical file.

Food and Nutrition

Food and Nutrition Service Definition

The service funded under this category is the provision of calorically and nutritionally appropriate prepared food which may include, but is not limited to, prepared meals, congregate meals, home delivered food, food banks, nutritional supplements, and the provision of nutritional counseling/education under the supervision of a registered dietitian.

Food and Nutrition Standards of Care

The overall objectives of the Food and Nutrition standards of care are to:

- assess and respond appropriately to the physical, nutritional, dietary, and therapeutic needs of clients;
- prepare meals in adherence with all safety, sanitation, and food handling/preparation standards for people living with HIV; and
- ensure that clients have adequate knowledge of nutritional needs and awareness of strategies to accomplish nutritional goals.

The service specific standards of care for **Food and Nutrition** provide additional requirements on the following components of service provision:

A. Agency Licensing and Policies

B. Competencies

Food and Nutrition services providers are expected to comply with the Universal Standards of Care, as well as these additional standards.

A. Agency Licensing and Policies

The objectives of the standards for agency licensing and policies for **Food and Nutrition** are to:

- demonstrate compliance with state sanitation standards and registration/licensing regulations; and
- provide services to clients in need.

A. Agency Licensing and Policies		Food and Nutrition Services	
Standard		Measure	
A.1	Agency complies with local, state, and federal sanitation and safety regulations.	A.1	Food and safety inspections by state agency and/or city agency.
A.2	Eligibility requirements include criteria for those who are unable or less able to purchase foods and/or prepare their own nutritionally adequate meals. Supplements are provided to those who are unable to eat solid food or require additional nutrition.	A.2	Written eligibility policy on file at agency. Clients receiving nutritional supplements have documentation of eligibility to receive supplements in their files.

B. Competencies

The objectives of the competencies standards for **Food and Nutrition** are to:

- provide clients with the highest quality services through experienced and trained staff; and
- ensure staff comply with all state and federal licensing guidelines.

At a minimum, all program staff hired to provide or administer food services will be able to provide appropriate care to clients infected/affected by HIV/AIDS and complete documentation as required by their positions. Clinical staff must possess the appropriate licensure, if applicable.

B. Competencies		Food and Nutrition Services	
Standard		Measure	
B.1	Staff have the skills, experience, registration, and licensing qualifications appropriate to providing food or nutritional counseling/education services.	B.1	Résumé and/or current license (e.g., certified registered dietician) on file.
B.2	Program staff are able to handle food safely (i.e., identify sanitation procedures for the purchase, receipt, storing, issue, preparation, and service of safe food and beverage products as required by state and/or local regulations).	B.2	Procedures on file relating to food preparation and handling. Documentation of staff certification in sanitation and food preparation and handling (e.g., ServSafe certification).

HIV Drug Assistance

HIV Drug Assistance Service Definition

The service funded under this category is the provision of medically prescribed pharmaceuticals used in the treatment of HIV and HIV-related conditions. This service is provided by covering either the full cost of medications, or the cost of premiums and co-pays for insurance policies with comparable pharmaceutical formularies.

HIV Drug Assistance Standards of Care

The overall objectives of the HIV Drug Assistance standards of care are to ensure that programs screen clients for eligibility for health insurance, other sources of reimbursement, and/or other benefits.

The service specific standards of care for **HIV Drug Assistance** provide additional requirements on the following components of service provision:

A. Eligibility

HIV Drug Assistance providers are expected to comply with the Universal Standards of Care, as well as these additional standards.

A. Eligibility

The objective of the eligibility standard for **HIV Drug Assistance** is to screen clients for eligibility for health insurance, other sources of reimbursement, and/or other benefits.

A. Eligibility		HIV Drug Assistance	
Standard		Measure	
A.1	Clients are screened for eligibility for health insurance, other sources of reimbursement, and/or other benefits.	A.1	Completed documentation of eligibility screening in client's file.

Legal Services

Legal Services Definition

Services funded under this category are those services directly necessitated by a client's HIV status including eviction prevention; employment rights counseling; bankruptcy proceedings; interventions necessary to ensure access to benefits; discrimination or breach of confidentiality litigation; and the preparation of powers of attorney, wills, and custody options for legal dependents, including standby guardianship, joint custody, or adoption.

There are no service specific standards of care for Legal Services. Please refer to the Universal Standards for the required standards for this service.

Mental Health Services

Mental Health Services Definition

Services funded under this category are psychological and psychiatric treatment, counseling, and case consultation services provided by professional therapists (licensed or authorized within the state). This includes ongoing treatment and/or short-term transitional services for those without access to other programs.

Mental Health Services Standards of Care

The overall objectives of the Mental Health Services standards of care are to:

- have policies in place to protect clients' rights;
- provide services with licensed professionals who have appropriate education and experience; and
- assess and respond appropriately to the routine and emergency psychosocial, cognitive, and emotional needs of clients with a range of psychosocial issues.

The service specific standards of care for **Mental Health Services** provide additional requirements on the following components of service provision:

A. Competencies

Mental Health Services providers are expected to comply with the Universal Standards of Care, as well as these additional standards.

A. Competencies

The objective of the competencies standard for **Mental Health Services** is to provide clients with the highest quality services through experienced and trained staff.

A. Competencies		Mental Health Services	
Standard		Measure	
A.1	Staff members are licensed, as necessary, to provide mental health services in Massachusetts and New Hampshire.	A.1	License on file in mental health, social work, psychology, or psychiatry for professionals providing mental health services. This typically includes psychiatrists, psychologists, and licensed clinical social workers (LICSW).

Peer Support

Peer Support Service Definition

Peer Support services are provided by and for individuals who are living with HIV/AIDS and help clients empower themselves and develop effective strategies for living healthy lives. Through one-on-one interactions and in small groups, these services support clients' engagement in health care and provide opportunities for education, skill-building, and emotional support in a respectful environment. With harm reduction as a foundation, peer support helps clients access health and benefit information, develop coping skills, reduce feelings of social isolation, and increase self-determination and self-advocacy, helping improve quality of life for both participants and peer leaders.

Peer Support Standards of Care

The overall objectives of the Peer Support standards of care are to:

- provide opportunities for sharing information and resources, with the goal of promoting self-advocacy; and
- facilitate the development of social and emotional support networks by and for people living with HIV/AIDS.

The service specific standards of care for **Peer Support** provide additional requirements around the following components of service provision:

A. Competencies

Peer Support providers are expected to comply with the Universal Standards of Care, as well as these additional standards.

A. Competencies

The objectives of the competencies standards for **Peer Support** are to:

- provide clients with the highest equality services through experienced and trained staff;
- ensure that peer support providers are able to provide culturally and linguistically appropriate services; and
- ensure that the provision of peer support service is documented appropriately.

A peer support client may disclose information within support groups or in one-on-one sessions that the individual has chosen not to share with a case manager and/or with another provider in the agency. When documenting peer support service provision, peer support staff should be aware of this and be sensitive to how and what information is recorded in the client's file. Documentation should identify general topic areas discussed during the session (e.g., disclosure, adherence, or risk reduction), but not an individual participant's comments, feedback, or thoughts.

A. Competencies		Peer Support	
Standard		Measure	
A.1	One-on-one peer support services are provided by people living with HIV/AIDS.	A.1	Peer support staff self-identify as people living with HIV/AIDS.
A.2	Peer support groups are facilitated or co-facilitated by people living with HIV/AIDS.	A.2	Peer support staff self-identify as people living with HIV/AIDS.
A.3	Provision of one-on-one peer support services is documented in client file, including date, duration, and general topics covered.	A.3	Documentation in client file.
A.4	Provision of support group services is documented, including date, name of group, number of participants, and general topics covered; client participation in support groups is documented in client file.	A.4	Documentation of support groups on file at agency; documentation of support group attendance in client file.
A.5	Peer Support staff (paid, stipend, and volunteer) will receive at least one hour of administrative supervision per month and one hour of clinical supervision per month. Administrative and clinical supervision should be conducted by separate individuals.	A.5	Signed documentation on file indicating dates of one-on-one and/or group supervision, type of supervision (clinical or administrative), and name of supervisor.

Primary Medical Care

Primary Medical Care Service Definition

Services funded under this category provide routine, non-emergency, outpatient medical care, case consultation, patient education, and OB/GYN services.

Primary Medical Care Standards of Care

The overall objectives of the Primary Medical Care standards of care are to:

- ensure programs are licensed and accredited;
- have policies that respond to the needs of incapacitated clients and that address advance directives; and
- provide high quality services with licensed staff.

The service specific standards of care for **Primary Medical Care** provide additional requirements around the following components of service provision:

- A. Agency Licensing, Policies, and Procedures**
- B. Competencies**

Primary Medical Care providers are expected to comply with the Universal Standards of Care, as well as these additional standards.

A. Agency Licensing, Policies, and Procedures

The objectives of the agency licensing, policies, and procedures standards for **Primary Medical Care** are to:

- demonstrate compliance with applicable federal and state regulations including licensing requirements for primary medical care; and
- have policies and procedures in place to protect clients' rights and ensure quality of care.

A. Agency Licensing, Policies, and Procedures		Primary Medical Care	
Standard		Measure	
A.1	Agency is licensed and accredited by appropriate state and/or federal agencies.	A.1	Current license(s) on file from appropriate state and/or federal agencies (e.g., clinic or hospital license).
A.2	Agency has policies and procedures to address the needs of incapacitated clients, including policies addressing advance directives and treatment and care decisions.	A.2	Written policies on file.
A.3	Agency has written information accessible to individuals concerning their rights under state law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives such as the Health Care Proxy or Durable Power of Attorney for Health Care.	A.3	Written policy on file.
A.4	Agency provides education to staff and clients about advance directives.	A.4	Written educational materials and resources made available to clients and staff, including referral information to legal advocacy services.

B. Competencies

The objective of the competencies standard for **Primary Medical Care** is to ensure that services are provided by staff who are licensed, as necessary, to provide primary medical care services.

B. Competencies		Primary Medical Care	
Standard		Measure	
B.1	Staff members are licensed, as necessary, to provide primary medical care services.	B.1	Copy of license in personnel file for each staff member. Professional diagnostic and therapeutic services are rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner.

Residential and Housing Support

Residential and Housing Support Service Definition

Services funded under this category include the provision of short-term emergency rental assistance, housing support services in a group home or scattered-site setting, and emergency housing-related expenses (such as utilities) to clients and their eligible family members. These services also include assessment, search, placement, and advocacy services provided by those who possess an extensive knowledge of local, state, and federal housing programs and how they can be accessed.

Residential and Housing Support Standards of Care⁹

The overall objectives of the Residential and Housing Support standards of care are to:

- ensure that programs are licensed and accredited;
- have appropriate policies and procedures in place to provide services;
- ensure clients are eligible for services; and
- reassess clients regularly.

NOTE: The standards of care for Residential and Housing Support are divided into two parts:

- ❖ **Part I** applies only to **housing advocacy/search** programs.
- ❖ **Part II** applies only to **supportive residential housing** programs.

❖ Part I: Housing Advocacy and Search Programs

The service specific standards of care for Residential and Housing Support provide additional requirements for **housing advocacy and search programs** for the following components of service provision:

A. Agency Policies and Procedures

Residential and Housing Support providers are expected to comply with the Universal Standards of Care, as well as these additional standards.

❖ Part II: Supportive Residential Housing Programs

The service specific standards of care for Residential and Housing Support provide additional requirements for **supportive residential housing programs** for the following components of service provision:

- A. Agency Policies and Procedures
- B. Competencies
- C. Intake and Eligibility
- D. Assessment and Service Plan

⁹ *Achieving Excellence: Standards of Care and Best Practices for HIV/AIDS Supportive Housing* (2004) is a useful resource that complements these standards of care. It can be accessed at www.ahc.org/publications_list.html.

Residential and Housing Support providers are expected to comply with the Universal Standards of Care (except as noted below), as well as these additional standards. **Supportive residential housing providers must also comply with all of the service-specific standards of care for Case Management (except Case Management Standard A.1).**

EXCLUSION: Supportive residential housing providers *are exempt from* Universal Standard 6.3, but must comply instead with the service-specific assessment and service planning standard below (D.1).

❖ PART I: HOUSING ADVOCACY AND SEARCH PROGRAMS

The standards of care in this section apply only to **housing advocacy and search** programs funded as part of **Residential and Housing Support**.

A. Agency Licensing and Policies

The objective of the agency licensing and policies standards for **Residential and Housing Support** is to ensure that **housing advocacy/search programs** document housing placements.

A. Agency Policies and Procedures		Residential and Housing Support	
Standard		Measure	
A.1	Agency maintains documentation of temporary and permanent housing placements.	A.1	Documentation in client file, including site, date of placement, and client and provider signatures; utilization data submitted to funder.

❖ PART II: SUPPORTIVE RESIDENTIAL HOUSING PROGRAMS

The standards of care in this section apply only to **supportive residential housing programs** funded as part of **Residential and Housing Support services**.

Important Note: In addition to the standards below, Supportive residential housing providers must also comply with all of the Service-specific Standards of Care for Case Management (except Case Management Standard A.1).

A. Agency Licensing and Policies

The objectives of the agency licensing and policies standards for **Residential and Housing Support** services are to ensure that supportive residential housing programs have appropriate policies and procedures in place to provide services.

Standards A.1 – A.4 below apply only to *congregate*, supportive residential housing programs funded as part of Residential and Housing Support services. Standards A.5 and A.6 apply to *congregate and scattered-site* supportive residential housing programs.

A. Agency Policies and Procedures		Residential and Housing Support Services	
Standard		Measure	
A.1	Property management policies and procedures exist. Policies and procedures address rent collection, unit inspections, work orders, maintenance, grounds upkeep, unit turnover, lease rule enforcement, evictions, and back-up personnel.	A.1	Written policies and procedures on file.
A.2	Procedures exist for providing advanced-stage health care, providing information or assistance with advance directives, and handling resident deaths.	A.2	Written procedures on file.
A.3	Policy exists for medication protocols describing the respective responsibilities of residents, staff, and health care professionals.	A.3	Written policy on file.
A.4	Policy exists on the use of drugs and alcohol, including protocols for handling relapse and negotiating referrals to treatment.	A.4	Written policy on file.
	Congregate providers that prohibit the use of alcohol and permit the use of urine screens must demonstrate that such policies and practices have been reviewed by agency legal counsel.		Documentation on file of review of policies by agency legal counsel.
A.5	Policy describing content of program agreement, including which activities are voluntary and which are mandatory, exists and is included in the <i>Client Rights and Responsibilities</i> document (Universal Standard 2.4).	A.5	Written policy on file and included in <i>Client Rights and Responsibilities</i> document (Universal Standard 2.4).
A.6	Tenant selection policy exists that clearly defines criteria for eligibility (as determined by the funding source) and suitability (client's ability to comply with the terms of the lease). Policy includes a provision for reasonable accommodations and a procedure for appealing denials.	A.6	Written policy on file.

B. Competencies

The objective of the competencies standards for **Residential and Housing Support** services is to ensure that congregate supportive residential housing programs protect the health and well-being of clients and staff.

Standard B.1 applies only to *congregate* supportive residential housing programs funded as part of Residential and Housing Support services.

B. Competencies		Residential and Housing Support Services	
Standard		Measure	
B.1	Staff members are screened for tuberculosis upon starting their jobs and every year thereafter.	B.1	Documentation of screening in personnel files.

C. Intake and Eligibility

The objective of the intake and eligibility standards for **Residential and Housing Support** services is to ensure that supportive residential housing programs are provided to eligible clients.

Standard C.1 applies only to *congregate*, supportive residential housing programs funded as part of Residential and Housing Support services. Standard C.2 applies to *congregate and scattered-site* supportive residential housing programs.

C. Intake and Eligibility		Residential and Housing Support Services	
Standard		Measure	
C.1	Residents are screened for tuberculosis as part of the intake process and every year thereafter.	C.1	Documentation of screening in client's file.
C.2	Clients meet eligibility criteria specific to housing programs.	C.2	Documentation of income and/or homelessness in client's file, as applicable.

D. Assessment and Service Plan

The objective of the assessment and service plan standards for **Residential and Housing Support** services is to ensure that supportive residential housing programs conduct regular, face-to-face reassessments with clients.

Standard D.1 applies to *congregate and scattered-site* supportive residential housing programs.

D. Assessment and Service Plan		Residential and Housing Support Services	
Standard		Measure	
D.1	Reassessments conducted at six-month intervals are face-to-face meetings between clients and case managers.	D.1	Documentation of meetings in client's file.

Respite Care

Respite Care Service Definition

Services funded under this category are residential and/or home-based non-medical assistance programs designed to relieve primary caregiver(s) responsible for providing day-to-day care. A caregiver is defined as someone who either cares for an HIV-positive individual, or is an HIV-positive individual who is responsible for taking care of children. These services are also available when an HIV-positive parent or guardian must go to a medical appointment and needs someone to care for his or her children during that time.

Respite Care Standards of Care

The overall objectives of the Respite Care standards of care are to:

- provide services by individuals aware of the respite needs of individuals living with HIV/AIDS or by individuals designated by the client as a member of his or her natural support network; and
- respond to the routine and emergency respite needs of clients.

The service specific standards of care for **Respite Care** services provide additional requirements around the following components of service provision:

A. Competencies

Respite Care providers are expected to comply with the Universal Standards of Care, as well as these additional standards.

A. Competencies

The objective of the competencies standards for **Respite Care** services is to ensure that clients have access to the highest quality services through experienced and trained staff or by individuals from the client's network.

A. Competencies		Respite Care	
Standard		Measure	
A.1	Staff have the skills, experience, and qualifications appropriate to providing respite care services. When the client designates a community respite care giver who is a member of his or her natural network, this designation suffices as the qualification.	A.1	Résumé on file.
A.2	If a respite caregiver is from the client's network, the client signs a disclaimer acknowledging that the caregiver may not always meet all of the requirements expected of the agency's paid staff, and that the agency is not responsible for any issues that may arise as a result of this arrangement.	A.2	Disclaimer, signed by the client, and filed in client's record, including the name(s) of the respite caregiver(s).
A.3	A respite caregiver from the client's network receives basic orientation or training on the provision of emergency and routine respite care services.	A.3	Documentation of orientation or training on file.

Substance Abuse Services

Substance Abuse Services Definition

Services funded under this category may include pre-treatment program of recovery readiness; harm reduction; mental health counseling to reduce depression, anxiety, and other disorders associated with substance abuse; drug-free treatment and counseling; neuropsychiatric pharmaceuticals; and relapse prevention in an outpatient or residential health service setting.

Substance Abuse Services Standards of Care

The overall objectives of the Substance Abuse Services standards of care are to:

- comply with state regulations, including licensing requirements, for substance abuse services; and
- provide services with skilled, licensed professionals with experience and/or education in relevant disciplines.

The service specific standards of care for **Substance Abuse Services** provide additional requirements around the following components of service provision:

- A. Agency Licensing and Policies**
- B. Competencies**

Substance Abuse Services providers are expected to comply with the Universal Standards of Care, as well as these additional standards.

A. Agency Licensing and Policies

The objective of the standards for agency licensing and policies for **Substance Abuse Services** is to ensure that programs comply with state regulations and licensing requirements.

If residential substance abuse treatment services are provided in a facility that primarily provides inpatient medical or psychiatric care, the component providing the substance abuse treatment must be separately licensed for that purpose. Ryan White Program funds may not be used for inpatient detoxification in a hospital setting.

A. Agency Licensing and Policies		Substance Abuse Services	
Standard		Measure	
A.1	Agency is licensed and accredited by appropriate state agency to provide substance abuse services.	A.1	Current license(s) on file.

B. Competencies

The objective of the competencies standards for **Substance Abuse Services** is to ensure that clients have access to the highest quality services through experienced and trained staff.

B. Competencies		Substance Abuse Services	
Standard		Measure	
B.1	Staff members are licensed or certified, as necessary, to provide substance abuse services and have experience and skills appropriate to the specified substance abuse treatment modality.	B.1	Current license and résumé on file.

Transportation

Transportation Service Definition

Services funded under this category include, but are not limited to, taxi vouchers and public and private transport services that enable clients and their caregivers to access HIV-related healthcare and psychosocial services. Cash or cash equivalents may only be provided to a client if the client is accessing mileage reimbursement and if the client documents the miles traveled in accordance with the agency's mileage reimbursement policy.

Transportation Standards of Care

The objectives of the Transportation standards of care are to:

- reimburse approved transportation services for eligible individuals living with HIV/AIDS and their caregivers;
- provide clients with the highest quality of services through trained and experienced staff;
- provide safe, timely, and reliable transportation services that facilitate access to medical and psychosocial services; and
- coordinate and administer services by qualified persons with designated administrative and program responsibilities.

The service specific standards of care for **Transportation** provide additional requirements around the following components of service provision:

- A. **Agency Licensing and Policies**
- B. **Program Safety**

Transportation providers are expected to comply with the Universal Standards of Care, as well as these additional standards.

A. Agency Licensing and Policies

The objective of the agency licensing and policies standard of care for **Transportation** is to ensure that transportation programs serving children are Medicaid providers or that they use Medicaid-eligible transportation services.

A. Agency Licensing and Policies		Transportation	
Standard		Measure	
A.1	Transportation programs serving children are Medicaid providers or use a Medicaid-eligible transport service.	A.1	Documentation of Medicaid status.

B. Program Safety

The objective of the program safety standards of care for **Transportation** is to ensure the safety of clients, including those with mobility impairments or other disabilities.

B. Program Safety		Transportation	
Standard		Measure	
B.1	Program has the capacity to provide transportation that is accessible to individuals with disabilities, as required by the ADA.	B.1	Funder site visit and/or contract monitoring process.
B.2	Volunteer ride programs are provided by trained volunteers who possess valid driver's licenses, liability insurance, and safe driving records.	B.2	Documentation on file, including copies of driver's license, liability insurance coverage, and driving record.
B.3	Volunteer drivers receive training on the agency's policies and protocols for health and safety related incidents.	B.3	Emergency protocol for health and safety related incidents is reviewed with all staff at least once per year and is posted in the agency.
B.4	Vehicles that are part of van or volunteer ride programs contain first aid kits.	B.4	First aid kits in van or volunteer ride vehicles. Funder site visit or contract monitoring process.
B.5	Volunteer and private transportation is provided in registered and insured vehicles.	B.5	Copies of registrations and insurance coverage on file.

Continued →

B.6	Volunteers who transport clients understand their responsibilities and obligations in the event of an accident, including the extent of their liability.	B.6	Signed and dated form on file that outlines responsibilities, obligations, and liabilities.
B.7	Operators of volunteer and private transportation agree to follow the established agency policy in the event of an accident.	B.7	Program has a written accident policy on file; policy reviewed and signed by volunteer and private transportation operators and kept on file.



Boston Public Health Commission
HIV/AIDS Services Division
Infectious Disease Bureau
1010 Massachusetts Avenue
Boston, MA 02118
(617) 534-4559



Massachusetts Department of Public Health
Bureau of Infectious Disease Prevention, Response, and Services
Office of HIV/AIDS
250 Washington Street
Boston, MA 02108
(617) 624-5300

This document can be downloaded from www.bphc.org/aids or www.mass.gov/dph/aids.

This project was supported by funding provided by the Boston Public Health Commission through Part A of the Ryan White HIV/AIDS Treatment Modernization Act of 2006, and by the Massachusetts Department of Public Health Office of HIV/AIDS.